Health and Welfare Canada
Santé et Bien-être social Canada

Family Violence Prevention Division

Division de la prévention de la violence familiale

National Clearinghouse on Family Violence

Centre national d'information sur la violence dans la famille

ELDER ABUSE: IT'S TIME WE DID SOMETHING ABOUT IT

by

Elizabeth Podnieks, RN, BScN MES

School of Nursing, Ryerson Polytechnical Institute
Family Violence Prevention Division
Toronto, Ontario

ELDER ABUSE: IT'S TIME WE DID SOMETHING ABOUT IT

by

Elizabeth Podnieks, RN, BScN MES

School of Nursing, Ryerson Polytechnical Institute
Family Violence Prevention Division
Toronto, Ontario

National Clearinghouse on Family Violence
Family Violence Prevention Division
Social Service Programs Branch
Health and Welfare Canada

Reprinted with permission from:
The Canadian Nurses Association, Vol. 81, No. 11 of
The Canadian Nurse (December 1985)

Cat. No. H72-21/9-7-1989E
ISBN 0-662-16656-6

ELDER ABUSE: IT'S TIME WE DID SOMETHING ABOUT IT

Elizabeth Podnieks, RN, BScN, MES

"I pushed her. I know I shouldn't have but I'd had a bad day and she knocked her false teeth off the shelf." (Nurses aid). "I don't want to go (into the nursing home) but my daughter says if I don't sell the house and give her the money she won't have anything to do with me any more." (elderly patient)

Elder abuse takes many forms. Sometimes, but not always, it involves physical cruelty. Sometimes family members are at fault. Sometimes it is caregivers. The problem is not new: gerontologists have known about it for years but recognition among the general public is just beginning to surface. Many of us would rather not think about the fact that the elderly among us are vulnerable, that in our own community there are people who need protection from family members or professional caregivers.

What drives a person to violence, particularly against someone he loves, or has loved, someone who trusts him or has trusted him? Why does love turn into hate and neglect? What tensions exist within families that such feelings of brutality are so near the surface? How can we as nurses be gentle and caring with our own mothers and grandmothers and then go to work and be impatient and careless with someone else's loved ones?

Accessing the mistreated elderly: indicators of abuse

Definition of abuse

Any act or behavior by a family member or person providing care (formally or informally) which results in physical or mental harm or neglect of an elderly person. This would include but is not necessarily confined to the following examples:

1.	**Physical abuse**	Willful, direct infliction of physical pain or injury. Denial of physical and health-related necessities of life.
2.	**Neglect**	Lack of attention, abandonment, and confinement of the elderly by family members or society.
3.	**Psychosocial abuse**	Removal of decision-making power from the elderly. Withholding of affection, social isolation.
4.	**Exploitation**	Any situation involving the dishonest use of an elderly person's resources, such as money or property. Misappropriation of health care resources.

Elizabeth Podnieks is a member of the faculty of community services, School of Nursing, Ryerson Polytechnical Institute, Toronto.

Victim profile	Abuser profile
Over age 75	Middle aged or older
Female/widow/single	Daughter/son of victim
Progressive physical and/or mental impairments	Experiencing stress: financial problems, medical problems, marital conflict, substance abuse, unemployment
Denies abuse: reluctant to report	Increasing demands of caretaking role depleting family resources
Increasingly dependent on abuser for physical/emotional needs	Resents role reversal with parent
Takes on role of child	Low self-esteem
Socially isolated	Impaired impulse control
May feel abuse is deserved	May have been abused child
May have been abusive parent	

Categories of abuse and neglect	
Physical abuse	**Indicators**
Assault, beating, cutting, burning, forced feeding, hitting, slapping, pinching, punching, pushing, pulling hair, shaking, shoving	Unexplained alopecia, abrasions, bruises, burns, bumps, contusions, falls, fractures, grip marks, hematomas, immobility, infections, internal injuries, lacerations, pain, restricted movement, rope marks, swelling, tenderness, ulcers, welts
Sexual molestation or rape	Pain, bruising, bleeding in genital area
Hypothermia	Shivering, cyanosis, lowered body temperature
Homicide	

Categories of abuse and neglect	
Neglect	**Indicators**
Withholding nutrition, fluids	Malnourished, emaciated, no dentures
Inadequate hygiene, personal care	Dehydration, mouth sores, confusion Decubitus ulcers, poor skin, hygiene, soiled linen, urine burns, unkempt appearance
Inadequate clothing	Clothes in poor repair, inappropriate for season
Overmedicated - drugs, alcohol	Oversedation - reduced physical/mental activity CNS depression
Undermedicated	Reduced/absent therapeutic response
Sensory deprivation	No glasses, hearing aid
Lack of safety precautions	Dangerous environment
Lack of supervision	Unattended, tied to chair/bed
Withholding medical services/ treatment	Not taken to doctor/dentist/ therapist
Unjustified use of restraints	Muscle contractures, immobility, weakness
Abandonment	Deserted
Forced entry into nursing home	Institutionalized

Categories of abuse and neglect	
Psychosocial abuse	**Indicators**
Humiliation	Appears shamed
Dehumanization	Low self-esteem
Intimidation	Withdrawn, passive
Non-verbal abuse/silence Fight-provoking	Fearful, "What are you going to do to me?"
Verbal abuse - shouting, scolding	Invalid guilt
Imposed social isolation Withholding of companionship/love	Excluded from family gatherings, not permitted to have friends, visitors, go to church
Removal of decision-making process	Loss of self determination
Infantilization	Ribbons in hair, toys, "baby talk"
Threats of abandonment, institutionalization, physical abuse, withdrawal of love	Depressed, hopeless, helpless

Exploitation	**Indicators**
Inequitable distribution of health care resources	Medical underdiagnosis/undertreatment Nursing attitudes - lack of understanding, custodialism, paternalism
Fraud, misuse of elder's money/property	Overcharged for home repairs, funerals "con artists", illegal use of elder's possessions/property/investments for profit/personal gain Abuser supports own drug/alcohol dependency

The causes of elder abuse are not well-understood; research points to a strong correlation between dependency, disability and abuse. Most caregivers are able to cope but some succumb to the unending burden of the caregiving role and express their stress in a violent way. Usually a combination of factors interacts to precipitate abuse: familial social/environment and pathological factors.

Hocking[2], a consultant geriatrician, has found that people who keep things bottled up are more likely to become violent. Could this not apply to a caretaker in the home, or a staff member in an institution? Both, feeling frustration and weariness, can so easily one day "let go" and vent all those pent-up feelings on the elder person who is a captive victim.

Individuals have differing perceptions and a variety of ways of defining violence. Bookin[3] in a recent paper cites an example of a social worker and her supervisor not being able to agree on whether a particular case was actually an abusive situation (the caregiver hitting the elder with a hair brush in order to control her). The picture became much clearer when, at the agency's annual family outing, the supervisor noted the worker physically disciplining her own child in public. The supervisor realized that she and the case worker had totally different notions concerning the use of force. We must carefully examine our attitudes and not be guilty of imposing our own biases on clients-at-risk.

Whether the caregiver is a tired, guilt-ridden family member or an overworked, underappreciated nurse, the stress, isolation and intolerable strain are similar. Eastman[4], a geriatric social worker, asked one of his clients if she ever felt like hitting the dependent person in her care and received the following response: "Thank God you've asked me that question. Yes, sometimes, I feel I could knock him sideways". Is there a message here for all of us? Would it be total heresy to say to a nurse, "Do you sometimes feel like hitting your client?" Will nurses ever feel secure enough, comfortable enough, honest enough to admit to themselves and to their peers some of their real feelings and anxieties about the caregiving role? How can we get across to caregivers that it's okay to feel anger, frustration, hostility? It is not okay to express these feelings in a way that threatens the recipients of our care.

We must learn to recognize stress signals and get help before these feelings are transferred to abusive behavior[5].

The elderly refuse to report abuse: they are mortified by the situation. They have many fears: loss of love, retaliation, relocation. Nurses too have great difficulty in reporting 'miscare'. We must make every effort to support our colleagues but let there be no misunderstanding: nurses don't have any option in the reporting of elder abuse. Even if the abuser is our best friend or the head nurse, we have an ethical responsibility defined by the standards established by the Canadian Nurses Association.

Documentation of elder abuse has increased significantly in the past few years. Nevertheless, accessing the mistreated elderly remains a major problem. Health care professionals often ignore or overlook the possibility of non-accidental injury and have not learned to recognize the signs and precipitating factors which can place the elderly in potentially abusive situations[6]. Studies have shown that abusers often do ask for help - only to find that no one is listening.

> "I am afraid I will lose control of myself. I might even murder her... I consulted my G.P., my minister, the district nurse, social worker and friends. No one seems able to help me...[7]

If anyone can reach the neglected or abused elderly, it is the nurse. The nursing process has prepared nurses to be particularly perceptive in identifying an elderly client in a crisis situation; the data she collects and her assessment and diagnosis determine the appropriate planning and management.

The initial interview will challenge all of the nurse's resources; she must maximize her observational skills and communication techniques. The abused client, who may have been living with pain and guilt for years, is anxious, probably ashamed, definitely afraid. The nurse must be watching for any cue or indication of stress in either the client or the accompanying caregiver. Collecting data from an elderly person is not easy: it requires patience, tact, discretion and above all a capacity to engender trust. How many of us would be willing to disclose information so embarrassing, so personal as the abusive behavior of the caregiver on whom we are dependent? We must be prepared to ask sensitive questions. We haven't been too embarrassed to ask our clients about their sexuality; now we must ask them how they really broke that arm, where did those bruises come from, why are they afraid?

Never make a nursing diagnosis of elder abuse until all assessments have been completed - history, physical and psychological examinations. Remember that sometimes the signs of physical abuse are actually due to the aging process[8]. Similarly, signs of psychological abuse may be due to social, cultural or other factors[9].

Fundamental to the intervention phase of the nursing process is the nurse's comprehensive knowledge of social supports and community resources. She cannot and must not intervene alone: she is part of a multidisciplinary team of coordinated workers. Intervention must include treatment modalities for the abuser as well as for the victim.

Intervention strategies require a continuum of care whereby the elderly person can move from one type of help to another as his health status changes.

Categories of abuse and neglect	
Exploitation	**Indicators**
Coercion	Forced to sign over control/ power of attorney Forced to change will, sell house
Resource abuse	Used as babysitter/housekeeper
Withholding pension/insurance cheque	No money for food/clothes Inadequate living environment Unable to afford social activities
Theft	Disappearance of elder's possessions in institutions

Observations which trigger further assessment
Presenting behavior of elder
Has physical/mental limitations affecting self-care ability
Medical history does not coincide with presenting injuries
Postpones seeking medical treatment
Has sores, injuries which have not been treated/partially healed
History shows repeated incidents of unexplained "accidents"/ injuries
Gives history of seeking medical attention from a variety of doctors/treatment centers
Gives information reluctantly: waits for caregiver to supply answers
Avoids physical, verbal contact with caregiver/professional

Cognitive responses of elder	
Affect, emotion:	Agitated, anxious, dejected, excited, fearful, flat, humiliated, overly quiet, resigned, unresponsive
Speech:	Hesitant, inaudible, loud, rapid, slow
Nonverbal behavior:	Cringing, hands clenched, rigid, rocking, passive, avoids facial, eye contact with caregiver/professional

Presenting behavior of caregiver
Refuses to permit hospitalization/diagnostic tests
Ignores elder's hospital admission - doesn't visit
May refuse to participate in discharge planning or take elder home
Impatient with staff/procedures
Appears fatigued
"Blames" elder
Responds defensively when questioned: makes excuses, hostile, suspicious, irritable, demanding
Does not want elder interviewed alone

Caregiver behavior toward elder
Excessively concerned/unconcerned
Treats elder like a child or nonperson
Has minimal eye, facial, physical, verbal contact with elder

Intervention	
Primary Prevention	
Legislation:	To establish legislative measures and policies which will protect the rights of elderly persons To provide health and social services which will maintain the independence of the elderly within the community or care facility
Advocacy:	To represent the views of the elderly To articulate their special needs To foster an appreciation of the developmental stage of the elderly
Research:	To determine the causes leading to abuse To develop a valid and reliable assessment tool
Education:	To increase public and professional awareness of the abuse problem To further understanding of the aging process

Secondary Prevention
Establishment of screening programs for elder abuse
Medical intervention for treatment of injuries; treatment of abuser
Develop plan of intervention to address elder abuse
Provision of protective services/legal intervention/guardianship
Coordination of community support system to ensure quality continuum care. Stress reducing measures through informal supports, networking, peer counselling and appropriate formal services
Family therapy involving elder, abuser, other family members
Educational programs to teach effective caretaking roles using a problem-solving process

Tertiary prevention
Rehabilitation, assisting the elder to achieve his/her optimum level of health and safety, may involve permanent change to create a more supportive environment
Rehabilitation of abuser - ongoing counselling, group support

High risk factors which precipitate elder abuse	
Familial	**Societal/Environmental**
Caregiver lack of knowledge of aging process and caregiving duties: services and resources available how to access them Psychological, physical impairments in elderly Age/psychological/physical health of caregiver Caregiver stress Caregiver pressured into caregiving role: guilt, financial reasons Caregiver has other dependents Poor family inter-relationships Multiple family problems Elder experiencing recent meaningful losses: bereavement, loss of independence, mobility Social isolation of caregiver and elder, lack of social and emotional support network Family history of violence Caregiver has poor impulse control Unreasonable expectations of capabilities of elder by caregiver or vice versa Substance abuse of elder or caregiver Altered lifestyle of caregiver Fewer available caregivers due to disappearance of nuclear family, i.e.: one-parent families Caregiver's refusal to accept, or fear of, own aging Role reversals, changing roles, role dissatisfaction Learned helplessness of elderly Refusal of elder and/or caregiver to accept help	Lack of societal concern for elderly Lack of understanding of aging process Stereotyping of elderly, ageism Inadequate resources - social services, social planning Poverty of women, financial stress, lack of reimbursement for caring for elderly at home Poor housing, overcrowding Unemployment of caregiver Fear of crime - inadequate safety measures in environment Lack of alternatives for elder other than institutionalization Lack of professional awareness of abuse problem - lack of detection/reporting protocols Lack of legislation dealing with rights of elderly **Institutional** Poor working environment Inadequate preparation of staff Lack of opportunity for staff professional/personal growth Increasing dependency of elderly, extreme impairments Lack of understanding of aging process, complex health needs of elderly Negative attitude toward aging Insensitivity to needs of elderly and families Lack of positive communication between staff/clients/families Lack of legislation and policies to ensure quality care in institutions

The ultimate goal of the continuum of care is to provide an active and fulfilling life in later years. A full range of home care and respite services includes: medical and legal assistance, visiting nurses, homemakers, home repair, friendly visiting, adult day care, respite care, physical and occupational therapy, nutrition services, telephone checking systems, transportation, emergency shelters, counselling and education, as well as providing assistance in learning problem-solving skills. Other interventions are: informal support systems (family, friends, neighbors, peers); local community organizations; gatekeepers (e.g. postal workers, delivery people, public utility workers); self-help groups, volunteers and resident counsels. These community-based supports are essential if elders are to remain in their own homes.

As practitioners, what can we do to become change agents in the social phenomenon of elder abuse? First, we can recognize the problem. We can be more sensitive to the dilemma facing those in the caretaking role. We can be aware of the diversity of social factors which precipitate violence. We can gain an understanding of how caregivers might react by being more aware of the methods we use to cope with stress and frustration[10].

We can think about the loneliness and isolation of the elderly person who is faced with loss of control and privacy. We can educate professionals and the public to detect and report abuse. We can foster the self-esteem and self-worth of all elderly persons, reverse the "learned helplessness" and "learned violence" that is transmitted from one generation to the next. We can lobby for legislation that will ensure the protection of elders, while acknowledging the importance of preserving the older person's autonomy.

REFERENCES

1. Golbe and Mail, Toronto. February 10, 1985.

2. Hocking, E.M. "Granny Battering" by S. Edwards, Medical News. November 1982.

3. Bookin, Deborah, Elder Abuse: Issue for the Practitioner. Presented at the Gerontological Society of America, November 1983, San Francisco, p. 9.

4. Eastman, M. "The Battering of Mrs. Scaffle" New Age, 1981.

5. Podnieks, E. Elder Abuse, Paper presented at the Second National Conference on Gerontological Nursing, Winnipeg, Manitoba, May 22, 1984.

6. Hooyman, Nancy and Tomita, Sue. Interventions in Cases of Elderly Abuse Within Medical Settings. Paper presented at the Annual Meeting of the Western Gerontological Society, San Diego, March 1982.

7. Eastman, M., Elder Abuse, Age Concern, 1984.

8. Humphreys, J., Campbell, J., Barrett, S. Clinical Intervention with the Abused Elderly and Their Families. Paper presented at the Gerontological Society of America, San Francisco, November 1983.

9. Eastman, M., Elder Abuse, Age Concern, 1984.

10. Parkin, M.W. Domestic Violence Against Women, Australian Nurses Journal. Vol. 12, No. 4. October 1982.

Canada